Montana Medicaid Claim Jumper Summer

Montana Medicaid CLAIM JUMPER

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CHIP Dental Benefit Limit

CHIP dental benefits are paid at 85% of billed charges for allowable procedures. The maximum dental benefit per child per benefit year (October 1 thru September 30) is $412 in billed charges or $350 paid. Dental providers write off 15% of billed charges until the child reaches the $412 limit. Enrollees may be billed for the full amount of charges that exceed $412 in a benefit year.

If the payment on the last line of your claim is reduced or paid zero with no explanation, check to see if the child has reached their CHIP dental benefit limit. If the benefit limit is reached on the last line of your claim the remittance advice will not include the reason due to a system change that was implemented in July.

Submitted by Patrick Brown, CHIP

Claim Attachments and the Paperwork Attachment Warehouse

There are two different ways you can send paperwork attachments to ACS. Providers can send the attachment as part of the claim or as a stand-alone document. When an attachment is sent either with the claim or with the paperwork attachment cover sheet, located at www.mtmedicaid.org, it will be scanned as a stand-alone document under the client ID number. This will allow the attachment to be used with other claims and by other providers.

If the claim is electronic, indicate the attachment by using the paperwork indicator in loop 2300 PWK segment 06. Send the attachment with the attachment cover sheet to ACS.

Attachments such as FA-455s, sterilization forms, and blanket denials that are used for multiple claims and providers should be sent as a stand-alone document with the paperwork attachment cover sheet.

Submitted by ACS

PASSPORT Summits Focus Group Is Being Formed

The Medicaid Managed Care Bureau would like to update providers on what's happened since the PASSPORT summits that were held this spring.

A focus group is being assembled to help guide the Department through the changes that will be implemented as a result of the summits. The committee will consist of primary care providers, specialists, office managers, hospital administration, and representatives from an IHS and Tribal Health Department.

The first focus group meeting is planned for early December. The Department has evaluated the comments and suggestions received at the summits and will present those ideas which reinforce PASSPORT objectives and have been determined to be feasible to the focus group. Members will work

with the Department to develop and implement these changes. Any suggestions made at the Summits which are not implemented will be addressed with an accompanying rationale.

We will continue to update you on our progress in later issues of the Claim Jumper. For further information about the summits and our activities, including meeting notes, visit the PASSPORT summits web page at www.mtmedicaid.org.

For more information about the PASSPORT To Health program, contact PASSPORT Program Officer Niki Scoffield at (406) 444-4148 or e-mail her at niscoffield@mt.gov.

Submitted by Anastasia Burton, DPHHS

Good-bye to MEPS

Effective January 1, 2006, MEPS will no longer be available. The HIPAA-compliant Montana Access to Health web portal will officially replace MEPS. Many providers have made the switch to the new web portal, and have discovered that it is user friendly with accurate, real-time information.

Providers across the state were offered trainings during the month of September. If you missed these trainings, you can still receive assistance by calling ACS at 1-800-624-3958 or 406-442-1837. Representatives are available from 8 a.m. until 5 p.m. to answer any questions that you might have. There is also a web-based tutorial available from the website.

In order to use many of the features available on the web portal, you must complete the Trading Partner Agreement, the Electronic Billing Agreement, and the EDI Provider Enrollment forms. These forms can be found on the Montana Medicaid website at http://www.mtmedicaid.org under the electronic billing tab. The forms are downloadable, and can be printed from your own computer.

The Montana Access to Health web portal is available 24/7 at:
http://mtaccesstohealth.acs-shc.com/mt/general/home.do

Submitted by ACS

Health-E Web Electronic Submissions and Paperwork Attachments

Health-E Web now allows for paperwork attachments to be sent electronically. Using Health-E Web, claims are now pre-processed electronically. The paperwork indicator is marked in loop 2300 PWK segment 06.

Submit your claim and mail the attachment along with the attachment cover sheet found at www.mtmedicaid.org. The claim will be matched up to the paperwork. The identifier entered on the cover sheet must match the identifier on the X12N transaction.

If you have any questions about this or any of Health-E Web's other submission requirements, you can contact them directly.

Submitted by ACS

Bundling for Critical Access and Exempt Hospitals

Montana Medicaid has until now required all hospital providers to:

a) Bundle outpatient hospital services, other than diagnostic services, that are provided within the 24 hours preceding the inpatient hospital admission, into the inpatient claim, and

b) Bundle diagnostic services, including clinical diagnostic laboratory tests, provided within 72 hours prior to the date of admission, into the inpatient claim.

However, that is no longer the case for critical access and exempt hospitals. Effective immediately the 24-hour and 72-hour bundling rules located at ARM 37.86.2918 (4) & (5) no longer apply to critical access and exempt hospital claims. This applies to critical access and exempt hospital claims processed on or after October 6, 2005.

Please contact the department at (406)444-4540 if you have questions about this notice.

Submitted by Bob Wallace, DPHHS

OCR and Pended Claims

OCR, optical character recognition, reads claims directly from their forms and processes them automatically. While the claims now process more quickly, providers may see more pended claims on their remittance advice, and for longer periods of time. This occurs because the claim is entered electronically and then waits for a person to adjudicate it.

Prior to implementation of the OCR, claims were entered manually and adjudicated at the same time. Rather than being held on a shelf until it is processed and adjudicated, the claim is now held in the MMIS system in a pended status. This does not mean that there is a problem; instead it merely means that providers can see these claims sooner than they could with the old system. In fact, claims that are sent in on the requisite red forms, and meet all the OCR requirements, are still processing faster than claims that were entered manually.

Submitted by ACS

Last Menstrual Cycle Dates and HIPAA Compliance

Menstrual cycle dates are often requested for pregnancy diagnosis codes. These dates are not HIPAA required, nor are they required for Montana Medicaid. Claims can be submitted without them for pay-

ment and will not reject for missing HIPAA required information.

Some software may require this information. If you believe that your software requires the last menstrual cycle date, you should contact your software vendor.

Submitted by ACS

Fall Advanced Medicaid Training a Success

We would like to thank all the providers who attended the Advanced Medicaid trainings in Livingston and Missoula. There were a lot of great questions and dialog. The feedback we received will be very helpful as we tailor these trainings to meet your future needs.

And another big thank you to the Department of Public Health and Human Services, who presented some very informative and helpful information. The topics covered were CHIP, PASSPORT, Team Care, Nurse First, Children's Mental Health, Comprehensive School and Community Treatment Program, the new Medicare Part D program and Big Sky RX, Physician Related Services Program and Outpatient Hospital (Common Hospital Edits).

If there are topics you would like to see discussed and presented at future provider trainings, e-mail mtprhelpdesk@acs-inc.com with the subject line " Topics For Future Provider Trainings".

In March 2006 ACS will be presenting a provider fair in Helena. The 1½ day seminar will feature a half-day coding training. Stay tuned for further information in upcoming Claim Jumpers.

Submitted by ACS

Making the Transition to the Medicare Prescription Drug Benefit

The new Medicare prescription drug benefit begins very soon, on Jan. 1, 2006. By now, most people who have Medicaid and Medicare know their prescription drug coverage will change.

Most important, Medicaid will no longer pay for prescription drugs for people who also have Medicare. People who have Medicaid only (no Medicare) will see no change in how they get prescription drugs.

Medicare assigned beneficiaries with Medicaid and Medicare to a prescription drug plan. Beneficiaries received a letter from Medicare in early November telling them the drug plan to which they've been assigned. In addition, beneficiaries will most likely be contacted by their assigned plan.

As with any new initiative, glitches may happen, especially with a program as massive as Medicare. If beneficiaries have concerns, for example, they haven't been assigned to a plan, or they were assigned to a plan that doesn't serve Montana, they should call 1-800-MEDICARE right away.

Beneficiaries need to be sure the plan to which they've been assigned is the best plan for them. Some beneficiaries may seek help from health care providers, especially doctors and pharmacists, to help them answer questions, such as:

- Can I continue to use my local pharmacy to get my prescription drugs?
- If I prefer mail order, does this plan offer the mail order option?
- Does the drug plan to which I've been assigned have all or most of the drugs I need on its formulary?
- If some of my drugs are not on my plan's formulary, what do I need to do to get the drugs I need?

All Medicaid and Medicare beneficiaries who have been assigned to a prescription drug plan will be enrolled in that assigned plan on Jan. 1, 2006. However, they are free to choose and enroll in a different drug plan before that date. They may need the assistance of their health care provider to make a choice.

Medicare approved prescription drug plans are required to have a comprehensive transition plan in place to make the change for beneficiaries as smooth as possible. Transition plans must be included in enrollment information given to beneficiaries. DPHHS and ACS are working with Medicare and the prescription drug plans to help people with Medicaid and Medicare through this change.

If you have concerns about a specific beneficiary with Medicaid and Medicare, or need more information about the Medicare prescription drug benefit, please contact Mary Noel at the Department of Public Health and Human Services, 406-444-2584 or manoel@mt.gov.

Submitted by Mary Noel, DPHHS

Indicators and the Pregnant Male

ACS has received claims for male clients with the pregnancy indicator. These codes are designed to override the cost share and PASSPORT requirements for pregnant females. This is happening both on facility and professional claims. Claims for male clients should never be billed to using these indicators

The indicator is marked at the claim level in loop 2000b pat segment 09 with a 'y' indicator. On a paper CMS-1500, the indicator is entered in box 24H, and on a UB92 the indicator is marked in box 78.

A system change is being made to deny for an invalid cost-share override. If you have any questions about the pregnancy indicator, please contact Provider Relations at 1-800-624-3958 or 406-442-1837.

Submitted by ACS

Cost Sharing: When Is It Taken, and How Much Is It?

Cost sharing is the client's financial responsibility for a medical bill as assigned by Medicaid. It is generally taken for services for adults, with a few exceptions. This is usually a flat fee, with the schedule as follows:

Inpatient Hospital
$100 per discharge

Ambulatory Surgery Center, Denturists, DME, FQHC, Freestanding Dialysis Clinics, Outpatient Hospital, RHC, Non-Emergent Care in ER
$5 per visit

Independent Diagnostic Testing Facility, Mid-level Practitioners, Physicians, Podiatry, Psychiatrists
$4 per visit

Dental, Home Health, LCPCs, Psychological Services, Social Worker, Speech Therapy
$3 per visit

Audiology, Hearing Aids, Occupational Therapy, Opticians, Optometric, Physical Therapy
$2 per visit

Public Health Clinics
$1 per visit

Pharmacy
$1-$5 per script
$25 monthly cap

Clients who reside in a nursing home, receive hospice, personal assistance, and home and community based services do not have cost share taken for any services. Pregnant women will not have cost share taken if providers use an appropriate EPSDT code, which indicates pregnancy. This indicator can only be used on females (please see this month's Claim Jumper "EPSDT and the Pregnant Male") and should only be used when the female is pregnant, through the covered post-partum period (which begins when the pregnancy ends and extends through the end of the month which 60 days has passed).

If a client has TPL or Medicare, cost sharing may or may not be assessed. If the TPL or Medicare pays on the claim, no cost share will be taken. However, if the claim is denied by TPL or by Medicare, the client will still be responsible for that cost share amount. This includes situations where the claim is applied to the deductible.

If you have any questions on cost sharing you can contact Provider Relations at 800-624-3958 or 406-442-1837.

Submitted by ACS

The Montana Medicaid Website: Finding What You Need

Answers to questions about fee schedules, provider enrollment, crosswalks, or newsletters, can be found on the Montana Medicaid website at
http://www.mtmedicaid.org.

The information available on the website is general information and does not require a user name and password. It can be accessed by anyone from any computer with Internet capabilities, and contains a wealth of information.

Here are some examples of information commonly requested.

Example 1: You want to enroll a new provider? Where do you go?

Answer: Go to www.mtmedicaid.org, from the menu on the left select Provider Enrollment, from there you will see a screen with all the forms necessary to enroll and become a Montana Medicaid or CHIP provider.

Example 2: You are a denturist and have read that the fee schedule has changed. Where do you go?

Answer: Go to www.mtmedicaid.org and select Resources by Provider Type. From the alphabetical list select your provider type. You will then see all the various resources available: Provider Manuals (including general), Medicaid Rules/Regulations, Fee Schedules, Notices and Replacement Pages, Other Resources, Remittance Advice Notice, and Key Contacts.

Example 3: You read that because of the implementation of HIPAA, Medicaid will discontinue the use of Medicaid EOB codes and begin using HIPAA standard reason and remark codes (R&R). Where can you find the information?

Answer: Go to www.mtmedicaid.org and select Resources by Provider Type. From the alphabetical list select your provider type, and then select Other Resources. There you will see EOB R&R Crosswalk. You can download the information and/or print it out for your own files.

Example 4: You want to begin submitting claims electronically. What do you do?

Answer: Go to www.mtmedicaid.org and select Electronic Billing. From there you can download the necessary paperwork needed to get a submitter number, and even software that will allow you to bill Medicaid electronically for free.

Example 5: You notice in the Claim Jumper that there are replacement pages for your provider type. What do you do?

Answer: Go to www.mtmedicaid.org and select Resources by Provider Type. Click on Notices and Replacement Pages, which will take you to that section. Choose the file you wish to look at and click on the link. Print off the pages and add them to your manual.

Example 6: I heard that there were some articles that might be of use to my staff and I in a Claim Jumper a couple of months ago. Where can I find old copies?

Answer: Go to www.mtmedicaid.org and select Newsletters. From

there you can choose either the Claim Jumper or the PASSPORT to Health Newsletter. Both Newsletters are currently downloadable through Winter 2000. You can download the information and/or print it out for your own files

These are just a few of the examples of the information you will find at www.mtmedicaid.org so go out there and explore. We are sure you will be pleased with what you can find.

All the files are downloadable. You do need an Adobe PDF reader so make sure you have the latest version installed.

Submitted by ACS

Electronic Claims with TPL

When submitting electronic claims for clients with other insurance, make sure the proper indicators are used. The electronic file created can deny based on improper use of insurance indicators – even when the information has been entered.

For example: A claim is submitted with an estimated amount to be paid from the patient's insurance company with the indicator showing as estimated. The TPL amount will not transfer through properly. In order to submit the claim to Medicaid the actual amount paid by the insurance company must be entered.

Another example is when the claim indicates the patient has TPL. If the self-pay indicator is used, rather than an insurance indicator, the dollar amount will not transfer through. Why? Self-pay is not an insurance type. There are several indicators available to show different insurance carriers.

The following is the X12 breakdown to show the actual dollar amount paid by the insurance company: Loop 2000B Medicaid needs to show as secondary. Loop 2320, segment SBR (indicate primary, secondary, or tertiary insurance), Loop 2320 AMT02 indicate actual dollar amount paid.

Please make sure to check which codes are appropriate for your situation. If you have any questions, you can contact ACS EDI at 1-800-624-3958.

Submitted by ACS

Eligibility Inquiries on the Web Portal

MEPS will no longer be available effective January 1, 2006. Providers will need to start checking eligibility on the Montana Access to Health web portal. If you haven't already registered for web portal access, please see an earlier article in the current Claim Jumper entitled "Good-bye to MEPS."

To check a client's eligibility, you will need either the client's ID number, the client's TEAMS ID or hard card number, or the client's full name and date of birth.

- After you have logged on to the web portal select Eligibility Inquiry found under the Inquiry Menu.
- Next, choose your provider number from the drop down menu.
- Enter the date of service for which you are checking eligibility. The information is considered accurate for the date of service you are looking up. The web portal will not give a compilation of eligibility history.
- Next, enter the client's ID or Teams ID number, and select submit.
- You will be shown a confirmation page showing basic information. If this information is correct, click on "View Client Eligibility."
- On the Eligibility Inquiry Response page, you will now see the eligibility information for the client in greater detail.

The information you will see includes the client's:

a) Demographic information

b) Eligibility span which includes your requested date of service

c) Managed Care information including the name of the client's PASSPORT provider and his or her phone number

d) Coordination of Benefits, if applicable to the entered date of service.

Another way to check for eligibility is with a client's name. There are four important things to remember when using a client's name to search:

1) When using a name search you must include the date of birth.

2) The name of the client must be spelled exactly as it is on the hard card, including a middle initial.

3) If a client has had a name change and Medicaid has not been notified, the new name will not pull up the client.

4) If you get more than one result, you will need to use the patient's Client ID to be more precise.

The preferred method of checking eligibility on the web portal is to use a client's ID or TEAMS ID number.

If you have questions you can call 1-800-624-3958 or 1-406-442-1837.

Submitted by ACS

Several Ways to Contact ACS Provider Relations

There are several different ways for providers to contact ACS for eligibility, claim, and other information.

1. Montana Access to Health web portal – With the web portal, providers have access to claim and

eligibility information, as well as information regarding their X12 and other reports. Previous payment information is also available. Information is available 24 hours a day, seven days a week and is updated in real time. Please see the article in the current Claim Jumper entitled "Good-bye to MEPS" for information on getting set up with the web portal.

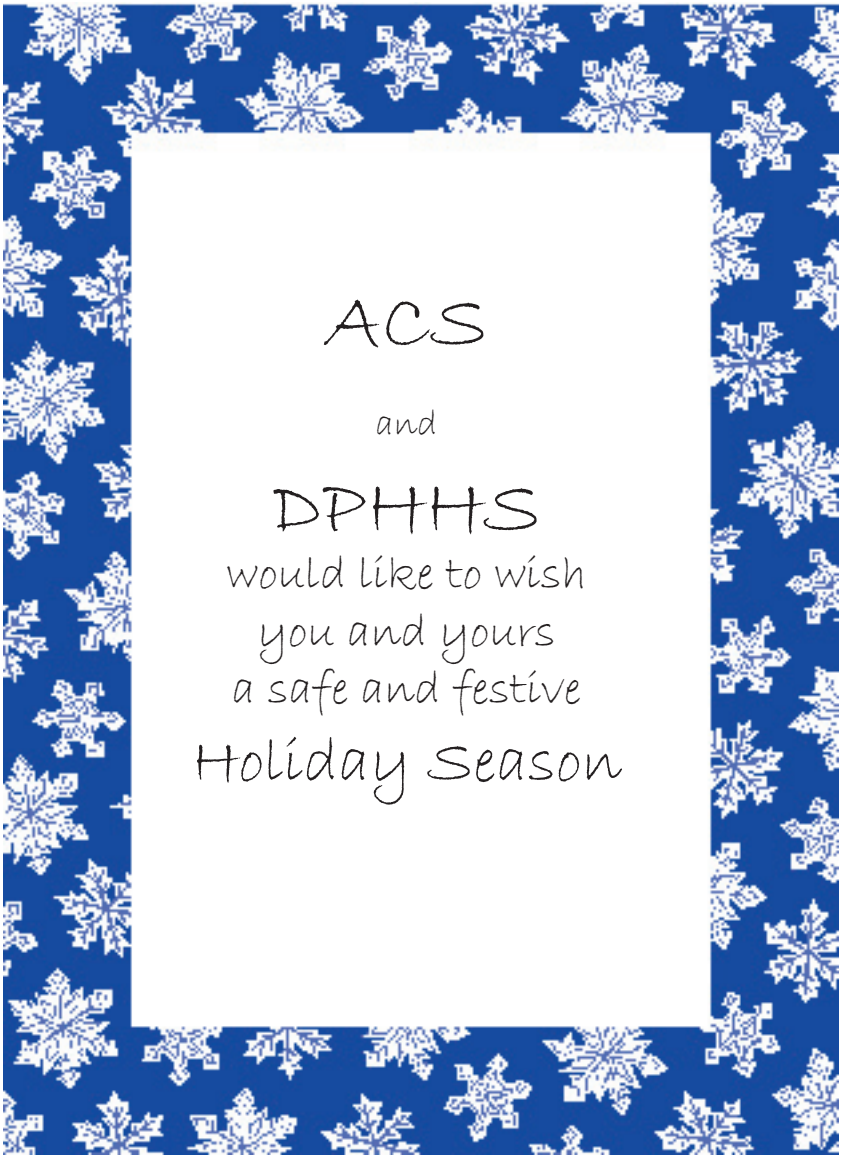
2. Phone – Call 1-800-624-3958 or 406-442-1837. Providers can contact ACS staff from 8 a.m. until 5 p.m. with questions regarding benefits, eligibility, claims, payments, and billing. EDI is open until 6 p.m. for questions regarding electronic billing.

3. E-mail–MTPRHelpdesk@ACS-inc.com or MTEDIHelpdesk@ACS-inc.com. Both of these e-mail addresses are checked daily, and questions will be answered within 24 hours during the normal work week.

4. Mail – You can mail eligibility requests and claims inquiry requests to ACS. These forms are available on the Montana Medicaid website (www.mtmedicaid.org) by clicking on Forms on the left side of the screen. Unless otherwise specified, the forms will be faxed back upon completion.

5. Fax – While this is not a preferred method of contact, eligibility and claims inquiry forms can be faxed to ACS, and will be faxed back when completed.

Submitted by ACS



Recent Publications

The following are brief summaries of recently published Medicaid information and updates. For details and further instructions, go to www.mtmedicaid.org and download the complete document fro Provider Information. Select ***Resources by Provider Type*** for a list of resources specific to your provider type. If you cannot access the information, contact Provider Relations at (800) 624-3958 or (406) 442-1837 in Helena or out-of-state.

Recent Publications Available on Website		
Date	**Provider Type**	**Description**
Fee Schedules		
10/13/05	School-Based Services	October Fee Schedule

Manuals/Replacement Pages		
10/06/05	School-Based Services	New Covered Services and Billing Procedures for CSCT and Therapy
10/12/05	Eyeglasses, Optometry, Optician	New Covered Services Information for Initial/New Prescriptions
11/02/05	Inpatient Hospital, Outpatient Hospital	Critical Access and Exempt Hospitals Regarding Unbundling
Notices		
10/04/05	Pharmacy	Pharmacy Audit Codes
10/04/05	Social Workers, Licensed Professional Counselors, Psychologists	Outpatient Therapy Changes
10/05/05	RHC, FQHC	Reimbursement Rates for Increase or Decrease in Scope of Service
10/06/05	Pharmacy, Ambulance, All Other Providers	Updated Remittance Advice Notices
10/11/05	Physical Therapy, Occupational Therapy, Home Health, DMEPOS, Nursing Facility, Physician, HCBS, Mid-level Practitioners	Wheelchair CMNs -- Transition Instructions
10/11/05	Inpatient Hospital, Outpatient Hospital	Critical Access and Exempt Hospitals Unbundling
10/26/05	All Provider Types	Call for Help with WINASAP 5.08
10/26/05	All Provider Types	Montana Medicaid Provider Website First Phase Completed; More Features Planned
11/03/05	All Provider Types	Revised Notice Regarding Problems with WINASAP 5.08
Other Resources		
10/03/05	All Provider Types	What's New on the Site This Week
10/04/05	All Provider Types	Updated Upcoming Events
10/06/05	All Provider Types	Updated Adjustment Request Form
10/06/05	School-Based Services	Updated School-Based Services CSCT Audit Checklist
10/09/05	All Provider Types	What's New on the Site This Week
10/14/05	All Provider Types	FAQs on Fraud and Abuse Contact Information Updated
10/17/05	All Provider Types	What's New on the Site This Week
10/17/05	All Provider Types	November Claim Jumper
10/17/05	All Provider Types	Help Instructions for Locating the Montana Access to Health Web Portal
10/'19/05	School-Based Services	METNET Q&A
10/20/05	All Provider Types	Train the Trainer: Medicare Prescription Drug Coverage Enrollment
10/24/05	All Provider Types	What's New on the Site This Week
10/24/05	All Provider Types	New General Key Contacts
10/24/05	All Provider Types	New Medicare Part D Fact Sheet
10/28/05	Pharmacy	Updated PDL and Quicklist
10/30/05	All Provider Types	What's New on the Site This Week
10/31/05	All Provider Types	PDF Version of All FAQs Updated to Reflect Previous Changes to Page
11/01/05	Pharmacy	Updated PDL and Quicklist
11/02/05	All Provider Types	Revised Fraud Numbers/Information and New PDF of All FAQs

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Key Contacts

Provider Information website: http://www.mtmedicaid.org
ACS EDI Gateway website: http://www.acs-gcro.com
ACS EDI Help Desk (800) 624-3958
Provider Relations
(800) 624-3958 (In and out-of-state)
(406) 442-1837 (Helena)
(406) 442-4402 Fax
TPL (800) 624-3958 (In and out-of-state)
(406) 443-1365 (Helena)
(406) 442-0357 Fax
Email: MTPRHelpdesk@ACS-inc.com
Direct Deposit Arrangements (406) 444-5283
Verify Client Eligibility
FAXBACK (800) 714-0075
Automated Voice Response (AVR) (800) 714-0060
Point-of-sale Help Desk for Pharmacy Claims (800) 365-4944
PASSPORT (800) 624-3958
Prior Authorization
DMEPOS (406) 444-0190
Mountain-Pacific Quality Health Foundation (800) 262-1545
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7961

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